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ABSTRACT

Addressed to the administrator of the hospital as well as the librarian, this handbook covers aspects of library service policy and long-range planning. While hospitals of all sizes are discussed, a special effort is made to cover problems of small hospitals (17 to 100 beds) in sparsely-settled regions. Contents: The library as a clinical service, Standards and accreditation (including reprints of standards of the JOINT Commission on Accreditation of Hospitals and of the Connecticut RMP Library Services); Balanced investment and level of service output; Audiovisual services; Regional (and national) affiliations for library service; Gifts; 24-Hour access; Centralized libraries and/or station collections; Multipurpose learning facilities; Library services to patients. Quotes from leaders in hospital library development are included, as well as references to the literature. Appendix gives addresses of resource libraries, Regional Medical Libraries, and national organizations; and a reprint of the evaluation questionnaire for libraries used by the Joint Commission on Accreditation of Hospitals. However, emphasis of the text is on cost-benefit factors rather than on the specifics of qualifying for accreditation. (Author)

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Hospital Library Handbooks
No. 2

HOSPITAL LIBRARY DEVELOPMENT

by
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Network for Continuing Education
Intermountain Regional Medical Program
Salt Lake City

January, 1972

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PREFACE

Readers of this manuscript have asked me to explain what I mean by a "small hospital." This is a good question, since the meaning of "small" is relative to experience.

For example, some years ago an eastern librarian wrote an article presenting the viewpoint of the small hospital. Her own hospital was small by Connecticut standards. It had a 200 bed capacity with a library of 2,000 books and 68 current journal subscriptions. There are 65 hospitals in Connecticut, a state which measures about 100 miles between opposite corners of the state. Of these 65 hospitals, 55% are larger than 200 beds. Only 28% are smaller than 100 beds.

In Utah there are 43 hospitals, of which 16% are over 200 beds while 72% are under 100 beds. Fifty-six percent are under 50 beds. The hospital which serves the miners' families in Carbon County has 70 beds--large for rural Utah--and is 64 miles through mountain passes from the nearest larger hospital at Provo (240 beds). Monticello (36 beds) refers its difficult cases to Grand Junction, Colorado, 180 miles by highway or 100 miles by air.

In sparsely-populated areas we cannot argue, on economic grounds, that small hospitals should be consolidated into larger units. We must find a feasible way of providing health care, including information, to Monticello. That feasibility must be consistent with an economic base of 36 beds, or less in other locations.

For this reason, the smallest level of service presented in this handbook is based on a much smaller library collection than the minimum proposed for hospitals in more heavily- settled areas. The larger library collection is certainly desirable, but if we do not have it we must find ways to get the job done anyhow.

Anne Cramer

INTRODUCTION

In a recent consulting visit, I was asked, "Why is it that we have this emphasis on better hospital libraries? Why is it suddenly everyone's great concern?" Later in that interview the same person remarked, "It seems that everyone on our staff has to relearn his job every three years." He had answered his own question.

The pattern of hospital library service is changing in response to the changing needs of the hospital. A nurse who drops out of work for a year will return to the hospital and be amazed at the new procedures which have been introduced in that short period. Education is now continuous, and all this learning must somehow be absorbed while the work of patient care goes on. The hospital staff do not have time to search out new information for themselves. Supervisors and education directors now plan educational programs for the general needs of the staff. The librarian's job has changed from a custodial function to one of active service. The librarian now searches out the information materials needed by individuals and by classes, so that the staff can spend their study time reading instead of searching.

The old pattern of library service was one of response to demand. The librarian waited until she received a specific request before looking for information. The emphasis was on service to doctors. Materials owned by the hospital, or by individuals on the staff, were the only materials available. The books purchased were the standard texts, which gave well-established information. They served to reinforce the physician's memory of his basic training. Since library users were well-acquainted with the standard literature, training for librarians emphasized the ability to retrieve known materials. At the same time, the few existing national bibliographies in medicine were very expensive, and inadequate as sources of cataloging information, with the result that every local librarian had to do her own cataloging. Once the catalog was made, the reader was expected to use it to find his own materials. Library collections were concentrated in large hospitals. Physicians in small hospitals were dependent on specialist consultants and on their own few journal subscriptions for new information.

Research findings are rapidly assimilated into today's medical practice. Patients in rural hospitals demand the same modern care that is available in large urban hospitals. Basic education for the allied health professions has been upgraded, so that many professions on the hospital staff have a scientific background for their work, and a need for current information. The allied professions are assuming many of the health care functions which physicians handled in earlier years. Continuing education is needed by all health care workers.

The modern hospital librarian anticipates the needs of her staff and directs information to their attention. She serves all members of the hospital staff from medical staff to orderlies. Where the old library emphasized local ownership of materials, the new library emphasizes the delivery of materials from sources owned nation-wide, through a network of cooperating libraries. The smallest hospitals can now give information services equal to the largest. Standard texts still serve their old function of refreshing memory, but rapid adoption of new procedures places emphasis on the most recent editions of those texts. Practicing physicians are making more use of research reports from the journal literature. The librarian must be able to locate articles from journals not in her own collection.

Librarians now have access to good and inexpensive national bibliographies. They must learn to use these bibliographies as keys to the literature which is available on loan from larger libraries. At the same time, catalog cards can be purchased from several sources, or copied from the printed catalogs of larger libraries, so that training in cataloging is not as important as it once was.

Hospital library collections, library services, and the training of hospital librarians is now entirely different from what we took for granted ten years ago. These changes are all a response to the need for constant retraining in the health professions. A well-functioning library service is a necessary part of the hospital's educational program.

It has been asked, "Why do we need a library? Our hospital is not a teaching hospital."

Can any hospital today fail to be a teaching hospital and continue for long to give modern health care?

The Joint Commission on the Accreditation of Hospitals is to be congratulated on its new interpretation of the standard for libraries (see p.14). That interpretation is completely output-oriented, concentrating on the service available to hospital staff. It is not concerned with the details input -- collections, manpower, space -- but only with the service output which is being produced. The standards for the service output are spelled out in detail.

The hospital administrator has many options in the combination input factors. Small hospitals will develop strong ties to larger libraries in the area and will depend heavily on inter-library loans. Large hospitals will fill more requests locally from their own larger collections. In either case there are many decisions to be made on details of collection size, manpower selection and training, and financial support needed for a given level of service.

This handbook is written to help the administrator make those decisions. We will give as much attention to the needs of small hospitals as to those of large institutions. We have given special attention to the practicality of the methods proposed. It is our aim to present -- not what the hospital ought to have -- but what value the hospital can expect to gain from any given level of investment in the library.

Throughout the handbook we will be concerned with maintaining balance between the resources which must all be provided if effective service is given:

1. Well-chosen and well-trained manpower
2. A current collection of information materials (bibliographies, texts, reference books, journals, etc.)
3. Appropriate space in the hospital

You will get better service from balanced library resources at sub-optimal level than you will get from a single resource, highly developed to the detriment of other factors.

> "A good hospital library is primarily a service which only incidentally requires a collection as one of its resources." (West, 1966, p. 577)

Although this handbook is addressed primarily to the administrator, it should be read in detail by the librarian as well. The most essential point in effective library development is that the administrator and the librarian understand each other's viewpoint and agree on their objectives.

The opinions and interpretations given in the handbook are entirely those of the author, and should not be interpreted as official policy of the Intermountain Regional Medical Program or any other agency.

THE LIBRARY AS A CLINICAL SERVICE

Why does the hospital have a library at all? What is the output of such a department? We have all heard enough about what the library does not have or does not do. What does such a department contribute to patient care when the library is operating properly?

Hospital journals have reported that effective library service does exist. Peninsula Hospital and Medical Center, Burlingame, California, has such a service. The librarian, Mrs. Prudence Hamilton, is the wife of a practicing internist, and she has been familiar with physicians' information needs since the early years of her marriage. She is an outgoing, sociable person who keeps up with current problems of the medical and nursing staff. As she hears of new problems, she searches the literature and sends photocopies of pertinent articles to the people concerned. She does not wait to be asked for that information. Of course, people know that she is helpful, so they do ask. She knows the staff and their continuing interests. As journals are received, she scans them for articles of interest and sends copies to the people who can use them. She drives to Stanford two or three times weekly to get materials not in her own library. Her service to the hospital gives equal emphasis to case-oriented material and to continuing education for the staff.

Mrs. Hamilton has supplied case-related materials on fracture of an amputation stump, subcapsular hematoma of the liver, champagne cork injury to the eye, effects of radiation therapy on the heart, and many more. She works from bibliographies and from MEDLARS computerized literature searches to draw on regional and national library resources.

Is this kind of service restricted to large hospitals? Dr. Martin Cummings, Director of the National Library of Medicine, has said, "The smaller the institutional library the more I believe it is possible for a person like Mrs. Hamilton to render extremely useful service." (Erickson, 1969)

At Bronson Methodist Hospital, Kalamazoo, Michigan, Mrs. Jan Hartenstein routinely sends journal articles to interested staff members. She also photocopies tables of contents of new books to send to all members of the medical staff. She does this routinely, and does not wait for special requests. ("Portrait of a Hospital Library," 1964)

The hospital library relates directly to two of the hospital's basic objectives: patient care and continuing education.

Case-related information may come from the standard reference materials which a doctor uses to refresh his memory. When the doctor needs to expand his basic knowledge of a case, his information must be delivered rapidly by a knowledgeable librarian. In a small, rural hospital the health workers may rely on a larger library some distance away, just as they rely on the telephoned advice of medical consultants. The librarian at the research hospital may even be working directly with the medical consultant on the problem. Because of the time factor in the value of case-related information, larger hospitals will try to have as comprehensive a library as possible at their own location. However, no collection can be complete. Swift communication with larger libraries is at least as important as the quality of the local collection.

Materials for continuing education are less specific and less closely tied to delivery time for their value. A flood of miscellaneous, unscreened information has little value for the busy health worker. These materials have their greatest value when they are related to some educational program: the formal program of the hospital or the current-interest profile of a staff member. Regardless of hospital size, it is imperative that the librarian know the details of these programs and interests. Where the library is a part-time job, the administrator might even consider combining the jobs of librarian and director of education. In any case, the librarian and the director of education must work very closely together, anticipating educational interests and making sure that materials are on hand when needed.

The administrator should expect his librarian to:

1. Maintain a collection of current reference books, bibliographies, and other materials according to a selection policy appropriate to the needs of the hospital.

2. Maintain interest profiles of staff members (formally or in her head) and direct current materials to their attention.

3. Work with the Director of Education in obtaining materials relevant to hospital-sponsored education programs.

4. Work with individual staff members in locating self-instructional materials for individualized learning programs.

5. On request, search the bibliographies for special topics, and obtain materials on interlibrary loan if they are not available locally. Develop special procedures for "rush" requests.

6. Supply facts as needed from locally-owned reference books.

7. Maintain records of the location of materials, whether in the hospital or on loan for home use and assure that location records are suitable for staff use when the librarian is not available for advice.

Will the administrator get this kind of service from his librarian?

The librarian will define her job as the administrator defines it for her. She will respond to the administrator's attitude more than she will respond to a formal job description. If the librarian's job is given to the librarian with instructions to keep track of the books, then that is exactly what she will do. She will keep track of the books, rather than keeping track of th information needs of the people who could be using books.

If the library job is given to a person whose professional committment is to another kind of work--nursing, medical records, social case-work--and that professional work already demands full time, then the library work will receive no time. The administrator may very well get better library service if he gives the library job to an intelligent office secretary, who normally budgets her day to cover several unrelated tasks, and if he outlines the kind of information alerting service he wants. The professionals know more about medicine, but the secretary may have more time to do the job. Whoever gets the library job, the administrator must assure her that library service is a proper use of her time. It must be scheduled into her work week and not put off as busy-work for idle moments.

As in purchasing books, larger hospitals can allow more time and other resources for library work; smaller hospitals must allow less.

The question is, how much more and how much less?

Many library standards have been proposed as attempts to answer the question. Some of the more widely-accepted standards are discussed in the next section.

STANDARDS AND ACCREDITATION

Even if accreditation did not exist, most hospital administrators would try to maintain the highest possible level of service. Regardless of the situation, whether in hospitals or colleges or other institutions, an administrator will not neglect an accreditation standard unless he honestly believes that the standard is irrelevent to his own situation.

This is the reason the new Joint Commission interpretation of its library standard is so excellent. It emphasizes service rather than ways and means. Interest in service, and ingenuity in using limited resources, will always give better results than large book collections which are poorly collected and poorly used. Accreditation standards based on size of book collections have always resulted in abuses. They fail to explain the end result that should be achieved. Emphasis on mere quantity really is irrelevent to institutional purposes. It is small wonder that administrators faced with quantitative accreditation standards conform to these standards with the least investment possible.

If quantitative standards are inappropriate for accreditation purposes, then what is the advantage of the many quantitative standards which have been proposed? In 1963, W. D. Postell proposed such a standard for book collection size in hospital libraries. In July, 1970, a workshop syllabus prepared jointly by the Arkansas University and the Arkansas Regional Medical Program adapted Postell's standards to the needs of smaller hospitals. Later in 1970 John Timour began to circulate standards which he and his advisory group prepared for the Library Services Project of the Connecticut Regional Medical Program (Connecticut 1970). In March, 1971, the Fact Sheet of the Pacific Southwest Regional Medical Library Service reprinted the Connecticut RMP standards with some minor changes reflecting needs in the West Coast area. What is the use of all this, especially if the standards do not agree with each other?

The answer is simply this: that the service-minded administrator needs some beginning estimate of the investment necessary for library services. Also, a study of the differences between standards will reveal the kind of options which are open to him in serving local needs.

Beyond these standards, the administrator needs to know:

1. What level of service can be given locally for each level of investment and

2. What regional contacts must be made to provide the balance of service.

In the sections that follow, we will give the different size standards which have been proposed, with some comparative notes. Then we will look at the kind of library service which the administrator can expect from each level of investment: what services can be provided locally, and which services must be referred to resource libraries. In short, we will try to explain what the librarian could be doing with her time and with the books.

W.D. POSTEL (1963):

Postell's standards are written for architects, to be used as the basis for space allowances in the hospital. Postell gives no suggestions for hospitals under 100 beds. He suggests that periodicals be discarded after 10 years since their most valuable content will be incorporated in the more recent books which are purchased. Older materials are used less and can be borrowed from resource libraries. After 15 years the discard of outdated books will begin to offset the purchase of new material.

HOSPITAL SIZE	-A- 100 to 300 beds	-B- 300 to 600 beds	-C- Over 600 beds
Journals Subscriptions @ 2 vol. per year for 10 years	35 titles 700 vol.	75 titles 1500 vol.	125 titles 2500 vol.
Book collection Collected in first five years	300 vol.	500 vol.	600 vol.
Additions per year thereafter	50 titles	75 titles	100 titles
for 10 more years=	500 vol.	750 vol.	1000 vol.
Total library after 15 years	1500 vol.	2750 vol.	4100 vol.
Shelving (one 3 ft. section holds 85 vols.)	18 sections	33 sections	49 sections
Study stations for . . .	10 readers	[25 to 30 readers]	50 readers
Workroom	120 sq. ft.	150 sq. ft.	200 sq. ft.

Neil Kelley and Sally Kasalko (Arkansas. . . Syllabus. . . 1970. p. 2) have made this adaptation for small hospitals, based on Postell's recommendations:

Size of Hospital	Under 25 beds	25 to 50 beds	50 to 100 beds
Basic book collection	50 titles	50 titles	100 titles
Books added annually	5 to 10 titles	10 titles	20 titles
Current journal subscriptions	10	10	20
Seating	5	5	10

CONNECTICUT REGIONAL MEDICAL PROGRAM (1970):

The following standards are a reprint of those prepared for the Connecticut RMP Library Services Project (1970) and adapted by the Pacific Southwest Regional Medical Library Service (March, 1971). When the two standards differ, the Pacific Southwest (PSW) version is given in parentheses. The variance may come from differing needs or from differing resources in the two areas, or from personal judgment based on differing experiences.

The main difference between Postell's standards and the Connecticut standards is in the balance between current journals and annual book purchases. As the output of research increases, journals assume more importance. The more recent Connecticut standards give more emphasis to current journals and less emphasis to standard textbooks. However, examination shows that the difference is not great.

SUGGESTED MINIMUM GUIDELINES FOR CONNECTICUT HEALTH SCIENCE LIBRARIES

These Guidelines have been established by the Connecticut Regional Medical Program's Technical Advisory Committee on Library Services which is composed of dentists, hospital administrators, medical librarians, nurses, and practicing physicians. These Guidelines are predicated on the existence of a single, health science library in each community hospital which will be responsive to the information needs of the community's health practitioners.

The operation of a school for health practitioners by the hospital, or the presence of resident students, imposes different requirements. These requirements may be found in publications of the accrediting bodies of the health programs concerned.

	HOSPITAL SIZE			
	-A- Up to 200 beds	-B- 200-400 beds	-C- 400-600 beds	-D- Over 600 beds
Library Staff	½ time employee (20 hrs./week)	1 full-time employee + p.t. clerk	1 professional medical librarian + p.t. clerk	2 professional medical librarians + 1 full-time clerk. Add 1 trainee or p.t. librarian per 50 beds over 700. (PSW: 1 professional + 1 library assistant + 1 full-time clerk)
Collection				
Books*	100	300	500	600
+ annual purchase	30	50	80	100
Journals (current subscriptions)	40 (PSW: 30)	60 (PSW: 60)	100 (PSW: 120)	150 (PSW: 150)

**Each hospital library should contain a core collection chosen by the Hospital Library Committee as best meeting the needs for current, comprehensive and authoritative literature of the various health professionals and health-related occupational groups for whom the Library serves as a resource. The Committee may endorse pre-selected and published core collections such as those by Stearns, Brandon, Yast and others, or it may establish its own. Locally chosen collections should reflect the same concern for currency, comprehensiveness and authority as do the published collections.*

Indexes**	-A- Up to 200 beds	-B- 200-400 beds	-C- 400-600 beds	-D- Over 600 beds
Abridged Index Medicus	Yes	Optional	Optional	Optional
Index Medicus	Optional	Recom.	Yes	Yes
(PSW: Cumulated AIM)	(Yes)	(Optional)	(Optional)	(Optional)
Cumulated Index Medicus	Yes	Yes	Yes	Yes
Hospital Literature Index	Yes	Yes	Yes	Yes
Index to Dental Literature	Yes	Yes	Yes	Yes
International Nursing Index	Yes	Yes	Yes	Yes
(PSW: Cumulative index to Nursing Literature)	(Yes)	(Yes)	(Yes)	(Yes)

***Hospitals of more than 400 beds (categories C and D) and those which have residential on-going programs in health education should consider including the following special indexes among its basic book collection:*

1. Quarterly Cumulative Index Medicus 1927 – 1956
2. Current List of Medical Literature, 1950 – 1959
3. Cumulative Index to Nursing Literature, 1959 – 1966
4. Nursing Studies Index, 1900 – 1959

Serious consideration should be given to physically segregating a core collection from the balance of the collection in order to assist users in quickly finding an authoritative work in each field.

Binding or microforms 25% of currently received subscriptions.

(At least 5 year runs of unbound and 10 year runs of bound volumes to be kept in the library).

Hours of Operation

All libraries, though not necessarily attended all of the time, should be accessible to the population they serve 24 hours per day.

Physical Plant

The hospital library should not be used for conferences or meetings or be located in a restricted area.

Reader seating space

Ten percent of the professional staffs, health workers and health students affiliated with the hospital.

Work space (enclosed)

150 sq. ft. per employee, including part-time personnel.

Shelving

Journal display: 5 linear feet for every 4 current subscriptions. Books and/or bound volumes: 5 books per linear foot (about 100 books per standard 3 ft. section).

The Library Committee

1. Membership

The person responsible for daily library operations should be a permanent member of the hospital library committee. Other members should be selected from the services represented in the hospital, one of whom to be designated Chairman. Selection criteria for membership might be weighted in favor of those actively involved with in-service and continuing educational programs. Administrative and allied health departments should not be overlooked. Staggered terms or rotational representation are preferred to an overly large committee, especially in those hospitals engaged in teaching and research.

2. Meetings

The Hospital Library Committee should meet at least quarterly. More frequent meetings are desirable and may be necessary to insure the adequacy and currency of the collection.

FINANCING HEALTH SCIENCE LIBRARIES

The following cost factors are offered as being representative for each category. These figures are as of April 1970 and will give those interested in Connecticut health

science libraries some idea of the financial dimensions of the Suggested Minimum Guidelines.

SALARIES

Professional Medical Librarian	$9,000.00 per year
Non-professional librarian	6,000.00 per year
Clerical Assistant	4,400.00 per year

MATERIALS

Books (average)	22.50
Journal subscriptions (average)	21.00
Binding (average)	5.25 per volume
Microfilm (average)	5.00 per volume
Supplies (all types)	.50 per year per book

The following average annual budgets are based on the above:

	- A - Up to 200 beds	- B - 200-400 beds	- C - 400-600 beds	- D - Over 600 beds
Salaries	$3,000.00	$8,200.00	$11,200.00	$22,400 on up (PSW: $19,400)
Materials				
Books	675.00	1,125.00	1,800.00	2,250.00
Journals	840.00	1,260.00	2,100.00	3,150.00
	(PSW: 630)		(PSW:2520)	(PSW: 3780)
Indexes*	173.50	198.50	198.50	198.50
(PSW**:	56.50	179.50	179.50	179.50)
Binding	52.50	78.75	131.25	199.50
	(PSW:None)		(PSW:157.50)	(PSW: 196.50)

PSW: "Libraries in category 'A' should consider retaining only 5-year files and do no binding. . . ."

Supplies	100.00	175.00	290.00	350.00
Sub-total Materials	1,841.00	2,837.25	4,519.75	6,148.00
Total salaries & Materials	4,841.00	11,037.25	15,719.75	28,548.00 on up
(PSW:	4,461.50	11,018.25	16,147.00	26.156.00)

**Recommended Indexes (Conn.)*

Abridged Index Medicus	*$ 12.00 per year*
Cumulated Index Medicus	*90.50 per year*
Hospital Literature Index	*10.00 per year*
Index Medicus	*63.00 per year*
Index to Dental Literature	*20.00 per year*
International Nursing Index	*15.00 per year (1971: $25)*

***Recommended indexes (PSW)*

Cumulated Abridged Index Medicus [not available when Conn. standards were published]	*10.00 per year*
Cumulated Index to Nursing Literature [a west coast publication with national distribution, clinical orientation]	*22.50 per year (1971: $25)*

JOINT COMMISSION STANDARDS (1970):

The standards suggested by Postell and the Connecticut Regional Medical Program represent the probable investment which would be necessary to achieve the kind of library services which are recommended by the Joint Commission on the Accreditation of hospitals. The quantitative approach to standards is supportive of the Joint Commission's intent. The hospital resources which are invested in the library should result in the services described here:

Joint Commission on the Accreditation of Hospitals
Accreditation Manual for Hospitals. Chicago [1970]

Standard I

Library services shall be made available to the medical and hospital staff. There shall be books, periodicals and other materials appropriate to meet their needs.

Interpretation

The hospital's professional library service should be active, dynamic and capable of providing pertinent and useful biomedical information that will serve the programs of the hospital and the needs of the medical staff.

The extent of library services will vary with size and program of the library. Hospitals providing extensive library service should have the services of at least one full-time librarian. When the librarian is employed on less than a full-time basis, a suitably trained person should be available to provide library services.

The hospital's professional library services should include:

Reference service. The ability to suggest references and sources of information, as well as the ability to find facts within a reasonable period of time.

Document delivery service. The ability to respond to a reasonable request, either to produce published matter from the library's own collection or to acquire it from source libraries. Procedures should be developed for lending library materials, for accurately controlling loans and for filling photo-reproduction requests.

Audiovisual service. The ability to provide audiovisual material and equipment.

To furnish these services adequately, the commonly used current reference material must be provided in the hospital, including Index Medicus and other pertinent indexes.

In addition, there must be an adequate, readily available basic library that affords the staff prompt access to current material. This library should contain basic books and journals available in the fields in which the hospital provides services, as well as books in certain of the sciences basic to medicine, such as anatomy, physiology, pathology, biochemistry and pharmacology.

There must be evidence of a continuing effort to study the hospital's needs for professional library services, and to ascertain that provisions exist for such services. These studies should result in development of immediate and long-term goals, the support of a realistic annual budget and recommendations for the deletion and addition of books, journals and audiovisual materials.

BALANCED INVESTMENT AND LEVEL OF SERVICE

Although the various unofficial standards seem to disagree they are basically the same, as demonstrated in Figure 1 (p. 17). The variance is not a wide one, but it is enough to show that there is room for difference of opinion. Size alone does not indicate a hospital's needs. A specialized pediatrics hospital with a medical teaching function will need a better developed library in its own specialty field than a general-service community hospital of the same size.

The administrator must identify: 1.) where his hospital's library now stands relative to general standards; 2.) the service level he hopes to reach, as adequate to the needs of his own staff; and 3.) the intermediate short-term goals which can be reached on a year-to-year basis, as part of a directed growth plan.

Accreditation teams are perfectly well aware of the inadequacy of many hospital libraries. They know the impossiblity of suddenly establishing such service with untrained manpower and inadequate space. What they will look for is an awareness of the existing situation, an honest effort to give as much service as possible from combined local resources and borrowing, and a feasible plan for growth which will produce adequate library service at the local level within a specified period of time.

Regardless of the present size of the hospital, the growth pattern of its library must go through all the development stages of smaller hospitals as it moves toward its goal of large-hospital service. Each growth stage must be fully developed and balanced before moving into the next stage.

The service goal is defeated if an "instant library" is purchased from a basic list before the hospital can afford suitable space to house it or a librarian to develop its use by the hospital staff.

Where does your hospital now stand in the various levels of service, and how far do you think it could go?

SERVICE LEVEL I

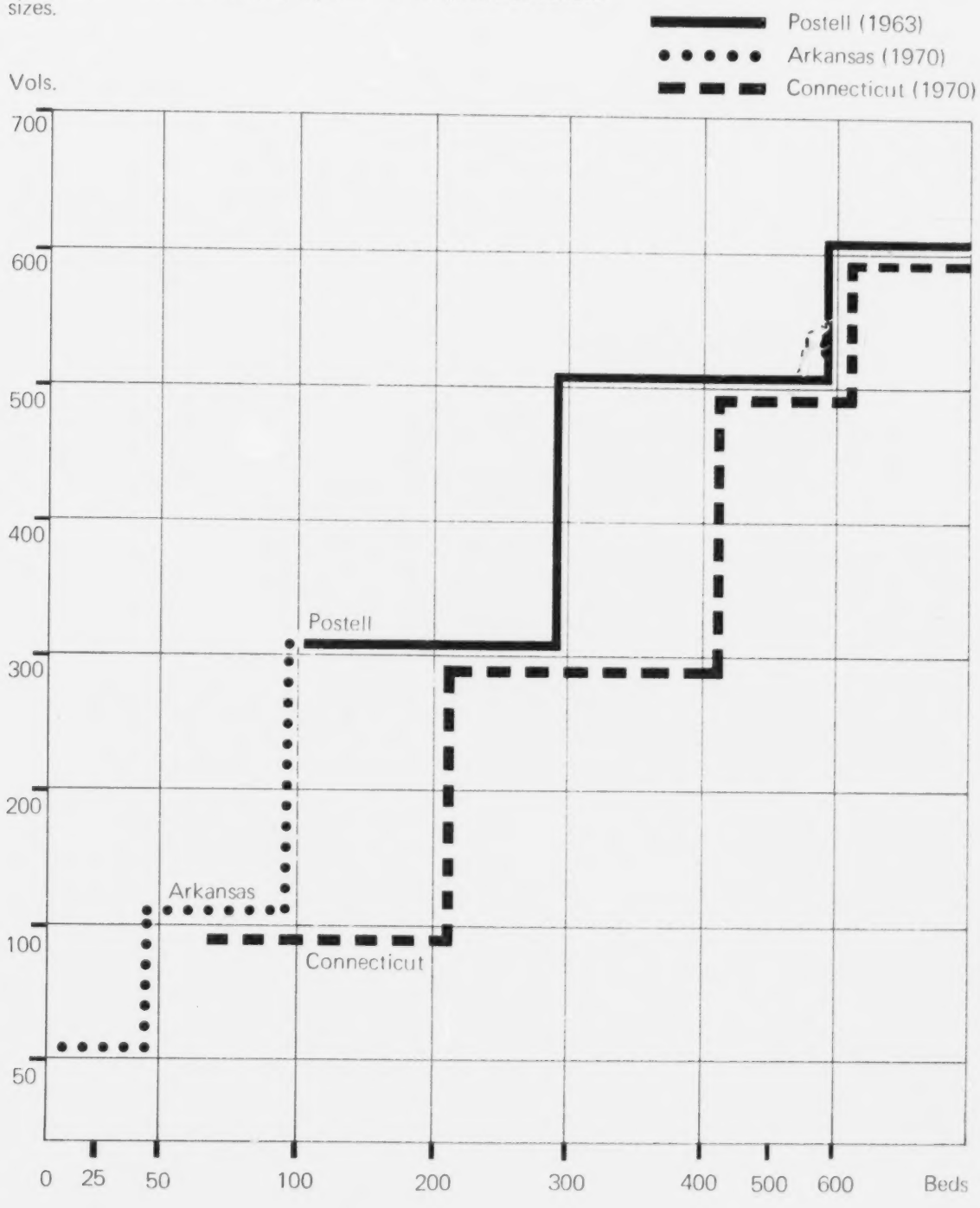
Level I will be given the most detailed description, because it forms the base level for all succeeding service levels. The smallest rural hospital could afford this level of service, and probably already has most of the components to achieve it. At this level a philosophy of service is established. Higher service levels are an elaboration of that basic philosophy.

The community which supports a 35 bed hospital (or less) seldom has local medical specialists. A surgeon may be on the staff, but the general practitioners are usually skilled in the more common surgical procedures. These men, and the nurses who assist them, see too broad a range of medical problems to depend on reading for detailed knowledge of all the specialty fields pertaining to their practice. They depend on a few general-coverage journals to give them a current awareness of trends in medicine, plus consultation with the medical specialists who do read the specialty journals. Continuing education courses give them pre-digested information on the new procedures which will be most useful to them.

The general practitioner has little need for a local supply of specialty journals in his own hospital, but he does need to have some kind of access to case-related specialty information when it is needed, and to printed materials related to his continuing education programs. Allied health workers in the small hospital have similar information needs in their own fields. Specialty information can be provided as needed, through interlibrary loans.

Figure 1

Basic text and reference collection to be collected in the first five years: Three standards proposed for hospitals of various sizes.



Although specialty materials are not heavily used, rural isolation does lead to greater dependence on locally-owned printed materials in general medicine, pediatrics and general surgery. A study of general practitioners in North Carolina shows that the smaller the town, the more journal subscriptions are carried by individual practitioners (excepting towns under 1,000 population).

Fig. 2 Number of Journal Subscriptions Carried by General Practitioners in North Carolina (Peterson, et. al., 1956).

Town Population	Under 1,000	1,000-2,499	2,500-9999	10,000-50,000	Over 50,000	Average for State
Subscriptions per physician	2.7	5.8	4.1	3.4	3.3	4.09

Library Collection. Library service in small hospitals consists of basic reference (finding those routine facts which cannot all be stored in the human memory) and interlibrary loans (obtaining specialized materials from a larger resource library). This can be done from a collection of fifteen to twenty reference books plus three or four bibliographies. Reference questions which cannot be answered from locally-owned materials can be referred to the resource library in the same manner as a request for a known title.

Manpower. Time is the resource most scarce for doctors and nurses. Whatever time they have for reading should be spent in reading, not searching. The librarian can help greatly by doing the searching, scanning each issue of journals and bibiliographies as they come in. She can find those articles which are pertinent to current cases in the hospital, or to current educational programs. In the small hospital this searching can be done in an hour or two each week.

The librarian could be anyone who is intelligent and inquisitive and sociable, who also spends enough hours in the hospital each day to know what is going on. Because of the need to know hospital problems, a part-time library job of less than twenty hours per week is usually given to someone who has another regular job in the hospital: administrative or medical secretary, education director, or records staff. Although some college training in biology might be desirable, basic intelligence and out-going personality are much more important in this position.

When the right person is located and assigned to the library job, she must learn how to use her reference tools and how to relay special requests to the resource library. The resource library can give advice on training. The Regional Medical Programs and Regional Medical Libraries often provide consulting services and training programs (see addresses on P. 45)..

The administrator should assure the librarian that library work is not incidental spare-time busy-work; that it is a regular job for which he expects her to budget a certain amount of time each week. Budgeted library time will include literature searches, checking in new journal issues, interlibrary loan correspondence, and an annual or semi-annual purchase order for new books. Reference questions requiring short, factual answers take little time, and they can be answered whenever they are asked, during blocks of time that are actually budgeted for other tasks such as typing.

The small collection in the small hospital needs no elaborate organization beyond an inventory list and journal check-in records. The librarian will notice missing volumes on a single scan of the reference shelf. She is personally acquainted with all borrowers, but a simple check-out system will probably be needed as an aid to memory.

Space and equipment. The "library" has no designated space of its own in the small hospital. Its single bookcase is located next to the desk where the librarian does her other major work, in a centrally-located, easily accessible part of the hospital. Busy hospital workers seldom think of going to the library. Health workers seldom see learning as urgent on a day-to-day basis. Learning can easily be put off until the days add into years and the staff is out-of-date. The library must be located so that the staff can find it without special effort, in the traffic pattern of more urgent activities. The librarian must be in a position to meet and visit with staff members often.

Even though the library described here has no designated space, it is capable of giving full library service through its telephone or postal contacts with the nearest resource library.

SERVICE LEVEL II

As soon as the staff becomes accustomed to the services provided at Level I, they will want to receive materials more quickly than interlibrary loans can provide them. An increase in caserelated reading will justify the demand for faster local access to library materials.

When the same text or journal has been borrowed several times, there is a clear indication that the hospital should own its own copy. Demand will probably indicate that at least one medical text and two or three texts in nursing and allied fields should be provided in each area: medicine, surgery, obstetrics and gynecology, pediatrics and emergency procedures. (Aquinata, 1968)

As the library grows, the same indexes and reference books will be continued from Level I. More texts and journals will be bought. With the help of a library committee the librarian will study one of the basic book lists and select the specialty fields in which texts and journals should be bought. It is unlikely that smaller hospitals will select the entire Stearns and Ratcliff core library (1970), although the complete list does insure coverage of the major specialty fields. The library committee must use its own judgment in spending its available funds for the subjects most needed.

At this point, the medical staff may decide to pool their own financial resources to buy the books and journals which they all need occasionally, but not often enough to need in their own offices. These purchases need to be placed in a central, accessible place. The hospital library is the logical location.

Most hospital libraries are financed from the combined resources of the hospital's general operating funds and medical staff library assessments. Financed from two sources, and serving all health professionals, the library must have an advisory library committee which represents all elements of its user population.

The growth from Level I into Level II no longer fits into a reference shelf by the librarian's desk. The most-used reference tools will probably stay where they were before, but basic texts and the first year or two of journals will require a full bookcase, three feet wide and six shelves (84 to 90 in.) high. As the collection grows past fifty text titles, and a five-year back file of journals accumulates, a second section of 3-foot-wide shelving must be added.

A study table and one or two easy chairs would be welcome comforts. However, the librarian has one or two other jobs besides the library, and her desk is in the line of traffic. Readers appreciate this easy access to the library but they probably will not stay in the library for prolonged and serious study. The table and chairs will be used for quick reference and for examining materials before taking them to the quiet of home or office. As growth approaches Level III, the administrator might consider remodeling to provide a small library alcove with sound controls. Such an investment would probably give only temporary advantage unless the number of beds in the hospital is expected to remain static. A building program which increases the number of beds should include designated space for the library: a special study room with separate office and work space for the librarian.

More books require more records. The simplest record is the inventory list. Collections of over 50 text titles may need cataloging and a simple subject classification for shelving. (Colaianni & Mirsky, 1970; Wilson, 1970). The librarian must also have a system for recording the texts which have been taken home for study.

More reference questions can now be answered locally instead of referring them to the resource library. Now that more journals are being received, the librarian will scan their contents as she checks them in, and will send pertinent articles to the people who would be interested. She will continue to scan the bibliographies for possible interlibrary loan materials. Library use tends to grow with programs of continuing and in-service education. The librarian begins to spend some time with the director of education. She prepares reading lists and obtains materials on loan from the resource library, in advance of need, for specific educational programs. At this service level the librarian will spend five to ten hours per week in work that is identifiable as library work, plus incidental time as needed for the simpler reference questions.

SERVICE LEVEL III

At first, Level III will appear similar to Level II except that the hospital and the medical staff organization provide more of everything, including more time for the librarian to handle the increased activity, and more space for books, for study, and for the librarian to work. This level would probably be supported by a hospital of 100 beds or more.

At Level III the collection in a general hospital will provide at least one current text in each of the specialty fields covered by the Stearns-Ratcliff core library, even if the exact titles may vary from the core library as listed. The journal collection, especially, will be expanded. A specialized hospital will purchase much more deeply in its own specialty area, rather than following the core library's pattern of balance.

As hospital size increases the medical staff will include more specialists. Medical specialists rely much more heavily on books than do general practitioners (California Medical Association, 1970, p. 37). A survey of physician's reading habits in Utah indicated that surgeons used almost three times as many library materials as did general practitioners, and other specialties showed similar increases. (Storey, Williamson & Castle, 1967?)

More specialists on the staff mean more reference work for the librarian, more interlibrary loans, and more requests for compilation of retrospective subject bibliographies from the library's indexes. At Level III the librarian's work will increase to fifteen or twenty hours per week.

When the librarian spends as much as twenty hours per week in the library she will know what is going on in the hospital without having a second, regular job. That is, she will know the hospital's interests, if the library is not hidden in a remote wing or basement.

This point in hospital growth often coincides with a building program which allows designated space for a library. The administrator must be careful that the library remains in the main traffic pattern of the hospital, even though noise controls will be necessary to encourage its use for study. Plans for library space should include office and work space for the librarian, separated from the study area. The librarian must have visual control of the library even though some noise control will be necessary to keep her conferences with staff and her occasional typewriting from disturbing readers. Glass partitions and carpeting are helpful.

If the librarian works 20 hours each week and does not have a second job to keep her in the hospital full-time, then there must be a second person on the hospital staff who can answer the simpler reference questions when she is gone, and keep track of the books which are borrowed. There must also be a procedure for recording more complicated requests, and for holding them until the librarian's return.

SERVICE LEVEL IV

After Level III has been well-established, the growth of the library can be described better in continuing trends rather than in plateau levels. At Service Level IV the collection will include about the same subject areas as in Level III, but gives a choice of two or three titles in each area. Some texts and journals will be added in sub-specialty fields, or for special groups of users such as nurses' aides and housekeeping staff. Some monographs may be added where the subject matter is of general interest to the staff.

A library of 300 books or more will be confusing to readers unless it is fully cataloged, including title and subject cards. It must also be classified into one of the standard systems for shelving (such as the U.S. National Library of Medicine classification).

Changes in hospital staff affect use of the library. Interns and residents in teaching hospitals give heavy use to the same textbooks which were kept on reserve for them at their medical schools. Students, house staff, and their preceptors are heavier users of books and journals than are physicians in private practice. Nursing students need immediate access to the basic core of materials in their nursing school collections, duplicated at the hospital. For hospital-based schools of nursing the hospital library usually incorporates the nursing school collection.

As growth continues, a subtle change is seen in the nature of interlibrary loans. Most of the routine requests can be filled at the local level, but the number of interlibrary loans does not decrease. They become more specialized as to subject content.

At first the half-time librarian puts in a little overtime; then overtime becomes routine (or quality of service goes down). Finally, the librarian points out to the administrator that the extra time might as well be scheduled regularly and included in the budget. The position gradually becomes a full-time job. In a 300 bed hospital with a well-developed library service, it is not unusual for the librarian to help five staff members in an hour, while involved questions must wait for a lull in business. As the service grows, the librarian will need a part-time clerk for her typing so that she can give her full time to service.

The administrator's greatest concern will be maintaining balanced growth so that whatever investment he puts into the book and journal collection returns its full pay-off through increased information delivery to the staff. The more journals are received and the more reference books are available, the more work-hours are necessary to maintain the alerting services and reference service which assure their full use. If the collection outgrows the librarian's time, then the investment in books will not give its full return. It would be comparable to a superbly-equipped and poorly-staffed laboratory.

SERVICE LEVEL V

By the time the hospital reaches about 400 beds its staff will include many specialists and subspecialists, including nurse specialists, physical therapists, inhalation therapists and perhaps clinical psychologists and social case workers. All of these people must have access to professional materials in their own fields.

The collection increases to about 500 book titles, plus journals. Service continues at the same level, but the librarian must be able to work easily in the subject matter of the specialties. Volume of business increases with the increased staff. At this level the librarian often finds that her collection has become a resource library for smaller hospitals. She may be giving indirect service to small communities by serving the specialists who confer with the general practitioners, and to whom cases are referred.

The untrained librarian who has been through each of the previous growth stages has learned a great deal from experience, and she may be able to handle this level of service quite well. This is especially true if she has had help from a professional library consultant. However, the self-trained librarian is often ready to retire, or leaves for some other reason, just as the library reaches its most demanding stage of growth.

The hospital administrator cannot hire a new, untrained person and expect her to do the job that the old librarian learned gradually over the years. Accelerated training up to this level of service means professional training, at an accredited library school.

Hiring a "professional librarian" costs more. If the administrator wants to receive full value for the librarian's salary, he must be careful to allow her the clerical support she needs in her work. The librarian who types her own catalog cards and reading lists is not a librarian for that period of time. During the time she is typing she is only a highly-paid typist, and perhaps not a very good typist at that. Clerical support is a good investment in the long run.

In the large hospital it is physically impossible to route all the traffic past a central point. Efficiency demands that activities be decentralized into separate wings and floors. The administrator should try to place the library close to one of the main centers of activity, such as the administrative area. However, it is inevitable that many health workers will no longer find the library by accident on their daily rounds.

When this happens, the librarian must make even greater efforts to reach the health workers. She must visit the wards more often. She must attend meetings of various staff groups to learn their problems and to offer services. She must use old-fashioned advertising at regular intervals, such as posters, bookmarks, reading lists, and a "new books" column in the hospital newsletter. She must give reference service by telephone to remote wards of the hospital, and she must arrange for books to be delivered to those wards.

SUMMARY

Study of these narrative "service levels" shows that they are very closely related to the quantitative standards which have been proposed. The main difference is one of emphasis. The standards are input-oriented. The service levels are output-oriented.

The size of hospital is only an indicator of the probable staff and its information needs. Libraries do not move suddenly from one status into another because of passing a certain mark in terms of beds. The character of a library changes in a continuum of growth, just as the hospital's character does. However, there are certain milestones along the way (expressed in bed size) at which the administrator, the librarian, and the library committee should pause and take stock of their progress. The rate of growth will never be perfectly even in all areas. Imbalance will creep in. Milestones such as these standards and service levels are an aid in restoring the balance between collections and manpower, finances and space, before the service output is badly affected.

AUDIOVISUAL SERVICES

THE FUNCTION OF AV IN LIBRARY SERVICES

We have seen that printed materials for libraries fall into specific types (reference books, indexes, textbooks, journals) according to the kind of information which each contains. Within each type of printed material some publications will be more suitable for the medical staff, and others will be more suitable for the allied professions.

The same is true of the different types of audiovisual media. Words, sentences, numbers and formulae are best able to carry abstract concepts and the logical development of ideas. The non-print media which make the heaviest use of words and sentences will be the ones best able to carry abstract ideas. Microfilm requires a projector, but it gives an exact reproduction of the printed page. Many librarians consider books and microfilm to be the same thing, and they do not even think of microfilm when they speak of audivisual media. The Audio-Digest news service is equivalent to a friend reading aloud from a medical journal. Lectures and discussions on audio or video tape carry a high level of intellectual content.

Libraries whose primary users are doctors will adopt these highly verbal forms of audiovisual materials first, before taking much interest in movies or filmstrips. Highly verbal AV materials fill almost the same intellectual function as books.

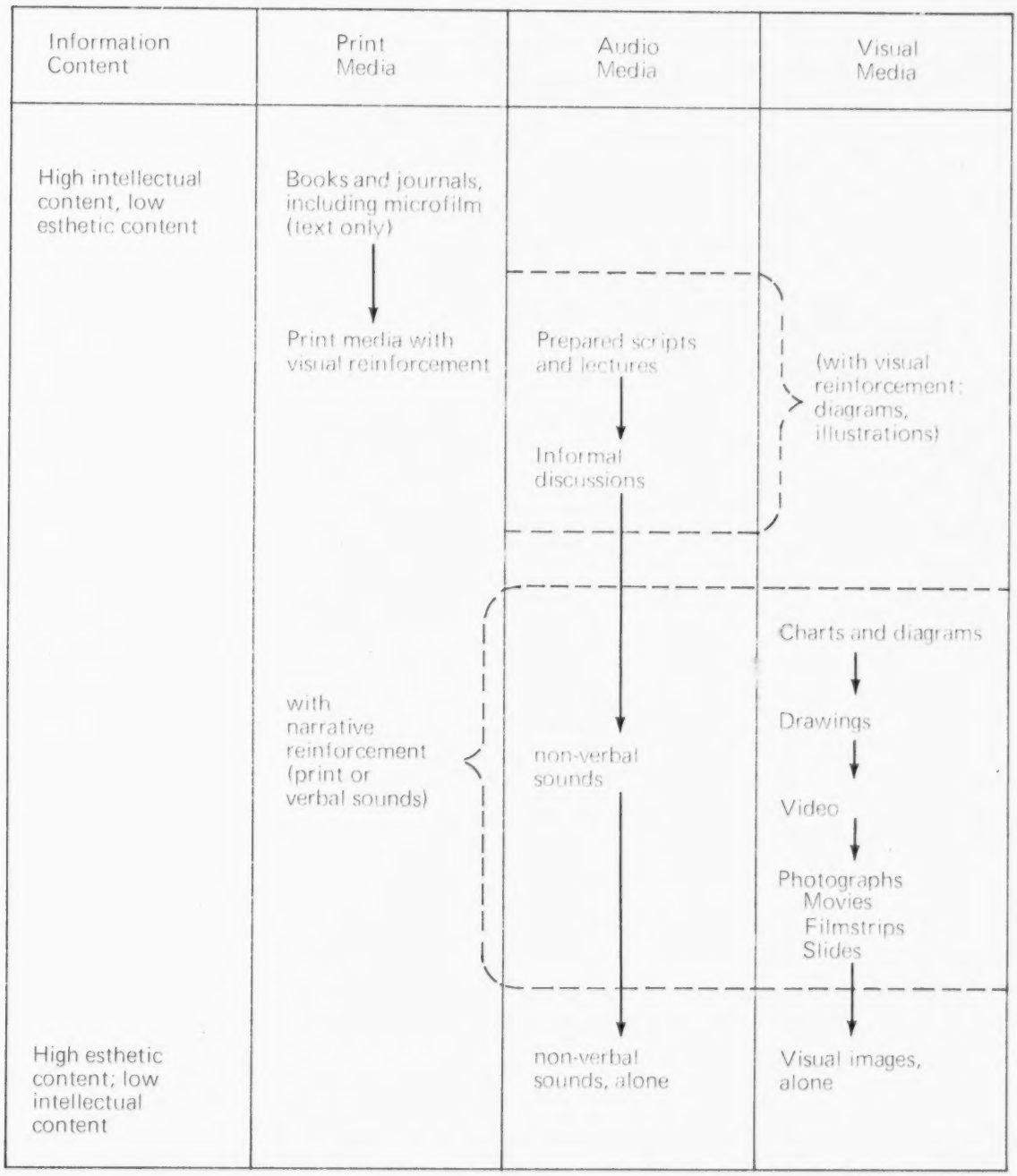
Less verbal audiovisual materials demonstrate the unique contribution which AV media can make in communication. They present a sight or sound as it appears, without analyzing it for expression in words. Slides, filmstrips, movies, and non-verbal audio recordings are recreations of acutal experience. Although they carry a much lower intellectual content, they deliver a much higher esthetic and emotional content than words can. They may be accompanied by verbal explanations, but the student's main basis for learning is his own direct observation. The accompanying verbal analysis reinforces the observation.

Audiovisual materials with low verbal content are well-suited for teaching identifications and routine procedures, for presenting simplified explanations of more abstract concepts, for producing desirable attitudes and responses in patient care, and for stimulating a desire for further learning. These materials are used extensively for inservice training of the hospital's nonprofessional staff, and for presenting the fundamentals of advanced medical concepts to the allied professional staff. These materials are essential to the hospital's educational program. Every hospital has at least a few of these materials, although they may not be located in the library. Often they are managed by the in-service training director or the supervisor of nurses. This is especially true if the library gives its primary service to the medical staff, or has a past history of such service. Often each department of the hospital buys its own AV materials, with risk of duplication.

Several factors indicate the desirability of centralizing audiovisual materials and services in the library. Centralized library services increase accessibility of materials to all members of the hospital staff, without restriction by department or profession. Just as the nurses need books, the doctors need nonverbal material. Continuing education programs for the medical staff now make heavy use of audiovisual materials to stimulate interest, and to save time in learning the fundamentals which are necessary for further study. Often the same AV materials can be used for many staff groups, depending on the kind of verbal reinforcement that is used with them. In addition to traditional classroom materials, there is a new emphasis on audiovisual materials for individual use, such as audio tape cassettes and 8 mm motion picture cartirdges. Many AV materials purchased for the classroom can serve double duty if they are accessible for individual use. The library is the logical location for indivdualized learning materials.

Figure 3

Gradation of information content in media, from intellectual to esthetic.



STANDARDS FOR AUDIOVISUAL SERVICES

Audiovisual materials have their own unique strengths and limitations, but they are carriers of information just as books are. Fully-developed audiovisual services will follow the same patterns which we have come to expect in book-related services: alerting services to make known the materials which are available; reference services to locate materials on demand; delivery of audiovisual materials to the user, either from the hospital's own collection or from resource collections; instruction in the use of audiovisual materials; and loan of materials for use by groups or by individuals outside the library.

The library will be a complete learning center with meeting rooms for groups and study areas for individuals. Meeting rooms and study desks will be equipped with appropriate audiovisual playback equipment. Some of the equipment for individual use will be compact and durable enough to be loaned from the library for use at home.

This picture is not a dream of the future. Medical schools and the larger hospitals are already providing this full range of audiovisual services. We have established patterns of cooperation so that the smallest hospital can deliver full book services to its staff. Now we must study ways for the small hospital to deliver full audiovisual services within its limited economic resources.

Detailed standards of service based on institutional size must be developed from a record of successful experience in prototype institutions. Until we know more about existing services we will not have a basis for judging minimum adequacy. We need to study the patterns of use in different types of hospitals and among different user groups before we can predict what should be owned locally and what can be borrowed.

Even while we are studying our audiovisual needs, we can use the idea of the information network as a model to build on. It works for books; it can work for AV media.

A basic collection of listening and viewing equipment must be available locally, either owned by the hospital or available from the community it serves. Selection of equipment for purchase will be determined by the kinds of films and tapes which the hospital expects to use most often, considering materials which can be borrowed as well as those which the hospital expects to own.

The library needs to keep a collection of audiovisual catalogs to use for locating the tapes, discs, slides and films which will be used on the equipment. The librarian will use these catalogs in the same way she uses indexes and bibliographies for locating books. Commercial catalogs list materials for sale or for rent. Resource libraries issue catalogs of materials for loan, either free or with a nominal service charge. State hospital associations can give help, either providing materials from a collection in their own central office, or acting as a clearinghouse for information on materials available from other sources.

Working with hospital education directors, the librarian schedules the borrowing of films and tapes just as she borrows books on interlibrary loan. Because of rental charges and service fees, the library budget must anticipate the probable cost of this service and allocate sufficient funds to support it. Some estimate must be made of the number of materials to be bought or borrowed in the course of the year. Materials which are borrowed frequently should be considered for purchase. Special materials, such as orientation materials for volunteers and new employees, may be specially produced for the hospital's own particular needs.

Because of the high cost of audiovisual materials, cooperation is especially important in this field. Where there are two or more hospitals in the same region, coordinated purchasing and borrowing can produce significant savings.

An active, well-developed audiovisual service will require library staff time in addition to the estimates given for print-related library services. However, assignment of this work to the library will be a time-saver for other departments which have been struggling with their audiovisual problems separately, and should result in better service than decentralized duplication of effort.

LIMITATIONS AND PITFALLS

Audiovisual production is an infant industry. Libraries and the ultimate users of AV materials must learn and grow with the industry itself.

In the fourth century A.D. the book replaced the scroll, and it has been the standard form for written material ever since. Even book sizes have been standardized since the days of handmade paper, so the librarian knows that 90% of her books will fit on a particular shelf size. (Most medical journals are the size called "quarto.") The struggles and experiments leading to those standardizations are lost in the mists of time.

We do not have that kind of standardization in the audiovisual industry yet. The situation is getting better all the time, but the problem of compatibility can lead to wasted time and money, and to frustrations in program planning. We order our film and it may come to us in a cartridge that won't fit our machine, unless we have planned ahead.

One key to a successful audiovisual service is the purchase of equipment ("hardware") which is known to be compatible with a wide range of available films or tapes or disc recordings ("software"). Regardless of the fine quality of a projector, it won't do much good if there are only a few film packages available in your subject field to fit it. Sometimes a software package designed for a special machine can be adapted to fit a more generally-usable machine. It is a simple matter to make 2 x 2 slides out of a 35mm filmstrip. However, these adaptations can be made only on the software you own. The machines you buy for use with borrowed software must be known to be compatible with a large supply of available software packages.

The audiovisual field is changing rapidly. With the best planning, we still find that yesterday's widely-used hardware does not fit the most common forms of today's software. Disc recordings have gone from 78 to 33 1/3 rmp and from monaural to stereo. The elaborate dial-access audio libraries of five years ago have already been made obsolete by inexpensive audiotape cassettes, which can be loaned like a book and used on home equipment.

It is important that new equipment be purchased with a view to developing trends, as well as the existing situation. Advance planning is always important, but especially so in audiovisual services.

GROWING INTO AV

A good set of AV software catalogs is a good starting point for your new audiovisual service. From these catalogs you can determine what software forms are most widely available. You will also need to make an inventory of the AV hardware and software already available in the hospital and in the community. You may be able to share equipment with the public library or the public school system. Home projection and playback equipment can be an important factor in your program, especially if you plan to loan software for use at home.

Your inventory will probably indicate these audiovisual forms for your first programs:

Audio-Digest and other audio tapes, especially in cassette packages. Doctors might contribute Audio-Digest to the library.

2 x 2 slides (easily synchronized with tape-recorded narrative)

16 mm motion picture films with sound

35 mm filmstrips (with printed or disc-recorded narrative)

For class instruction, an overhead projector is a good purchase. It provides visual reinforcement for lectures. It is a great improvement over the old blackboard, since it is easy to

prepare transparencies in advance and to store them for repeated use in the future. Although home-made transparencies may lack polish, they fill the audiovisual gap when commercially-produced materials are not available for the particular topic you need.

The most commonly available projectors and audio equipment cannot be used in the reading room of the library. Forward projectors require a darkened room, and loudspeakers are disturbing to readers. Some new equipment purchases will probably be necessary for use by individuals. Small rear-screen projectors can be used in normal reading light. These are available for 2 x 2 slides and for 8 mm motion picture loop cartridges. Mirror systems can be used to convert forward slide and film-strip projectors to rear-screen illumination. Earphones are the answer for individual audio equipment.

Universities and teaching hospitals are making use of television in their educational programs, and much of this material is available to smaller hospitals on video tape. This media makes it possible to share the influence of distinguished visiting professors and the intellectual stimulation of professional conferences. Video tapes of these programs are not usually available through commercial sources. Just as in the case of other hardware, the hospital should locate its continuing source of video tapes before investing in video playback equipment.

The hospital which can afford a complete television system —— cameras as well as playback units —— has a powerful teaching tool. Trainees can see their own working performance on the tape playback and study ways to improve their work. Students can view delicate procedures which they would have difficulty seeing if they were in the same room with the action.

For most hospitals, however, the success of their audiovisual services will not be determined by the variety or sophistication of their hardware. It will depend on informed and imaginative use of the limited equipment which they can afford. A successful program will depend especially on strong contacts with commercial and cooperative sources of software.

REGIONAL AFFILIATIONS FOR LIBRARY SERVICE

NLM EXTRAMURAL PROGRAMS

Regional Medical Libraries. For many years, the National Library of Medicine served as the main resource for medical information in the nation, and provided interlibrary loans directly from its own collection to whomever asked. In time, it became obvious that a single library could not respond directly to the needs of the entire medical community. At the same time, large academic and research libraries maintained large collections for their own use, and served only a limited outside need in their immediate geographical areas.

Libraries are usually generous by nature. However, they often do not have funds for manpower and costs to handle any great number of loan requests even if they already own the books. Also, coordination is needed to keep all the requests from flooding into a few of the better-known libraries. The National Library of Medicine Extramural Programs have provided leadership for national coordination. It has also provided funds for this biomedical information network as authorized by the Medical Libraries Assistance Act of 1965 (PL 89-291).

By common agreement the United States has been divided into eleven regions for medical library service.

Figure 4

Regional Medical Library areas sponsored by the National Library of Medicine.

If a region has a single medical library which is the acknowledged leader of the area, then that region is organized to give service from that major library. Such a region is said to be "centralized." (Countway Library in Boston has been designated as the New England Regional Medical Library.) The Pacific Northwest Region utilizes services from several libraries, but responsibility for program design is centralized at the University of Washington in Seattle. (Oppenheimer, 1971)

In regions where many good collections exist with none being preeminent, all are designated as resource libraries for the system. A central coordinating office is established to channel requests and equalize the load. The Midcontinental Region has been organized with central offices in Omaha, but requests are filled from resource libraries in Salt Lake City; Denver; Kansas City; Columbia, Missouri: St. Louis; Omaha; and Vermillion, South Dakota. All libraries share in responsibility for policies and programs. This is a "decentralized region." (Hetzner, 1971)

Boundaries of the regions are given in Fig. 4 . The Intermountain Regional Medical Program sponsors programs in parts of three library regions. Regional Library headquarters and the resource libraries in the area of the IRMP are listed in the appendix.

Library Resource Grants for Hospitals. All medical libraries in the United States are regarded as potential nodes in the medical library network. To improve the resources of all medical libraries, NLM gives resource grants funded under the Medical Libraries Assistance Act. That act has been extended until June 30, 1973. Resource Improvement Grants are available to institutions which need to improve or expand their basic collections and services. Resource Project Grants are available to libraries which are well established, but need help to implement special projects which would provide significant new materials or services for their users.

The only financial requirement made of the hospital is "that adequate and continuing financial support will be provided for the library during and after the period of Federal support. . . . Applicants for Resource Improvement Grants are also required to assure that they will provide, with non-Federal funds, minimum library staff and adequate space for the library functions." (U.S.N.L.M., 1970, pp. 30-1) In the case of hospitals, a minimum staff is considered to be a paid (non-volunteer) person who devotes half of the hospital's normal work-week to library activities.

Community characteristics are an important consideration in assigning priorities for awarding the grants. All health libraries are considered to be parts of the national network and are expected to cooperate with each other.

"The following factors will be considered in the review and evaluation of all applications:

1. The type and size of user population (students, faculty, physicians, hospital staff and practitioners in the sciences related to health).

2. The geographic area served the availability of other resources in the area.

3. The relevance and quality of the proposal.

4. Relationship to other libraries." (U.S.N.L.M., 1970, p. 8)

Hospitals which cannot meet the manpower requirement from their own staff will not be able to qualify for grants. However, they may be able to benefit from the resource grants through regional affiliations with other hospitals. An application for regional hospital service would probably receive a very favorable evaluation if its plans are well conceived and well developed. Such a grant would be awarded to the single hospital making the application, but smaller hospitals could contribute to the librarian's salary and other operating expenses in return for library services received. The

application for such a grant should be accompanied by letters from the administrators of cooperating hospitals, indicating their understanding of and full cooperation with the proposal as written.

For additional information, write to:

Chief, Resources Division
Extramural Programs
National Library of Medicine
8600 Rockville Pike
Bethesda, Maryland 20014

Other Extramural Program Projects of the N.L.M. The Medical Libraries Assistance Act provided funding for a number of other Extramural Program projects. These grant and contract projects affect hospital libraries indirectly, but they are vital to creating a climate in which the hospital library can flourish.

1. Research and development in medical library science and related fields. "Projects supported have included surveys on health library manpower, an on-line serials control system, studies of communication patterns among medical researchers, development of standard nomenclatures, evaluation of self-instruction materials, and language analysis for information retrieval." (Cummings, 1971, p. 381) These are the basic research projects which establish the need, or test the feasibility, of operational projects which come later.

2. Training in medical library sciences. With manpower needs identified, NLM can award grants to qualified institutions to provide special programs of instruction in medical librarianship. Hospitals once found it all but impossible to find professional librarians with training or experience to understand their needs. Now the situation is much improved, in quality and in numbers of librarians available. The graduate of an NLM-supported training program can be expected to have a thorough understanding of medical information and its delivery.

3. Biomedical publications. The publications supported by NLM tend to be the kind which help people find the information they need: abstract publications, giving summaries of articles with a complete citation to the original; bibliographies, giving lists of publications on special subjects; handbooks and catalogs, listing the holdings of large research library collections; critical reviews of recent publications; and translation projects, to make significant foreign publications available to English-language readers. These are materials which the hospital librarian can use to help the people she serves.

4. Construction of facilities. From 1967 to 1970 the National Library of Medicine awarded eleven construction grants to academic and research libraries which can serve as resource libraries in the national network. The construction program ended with the expiration of the original Medical Libraries Assistance Act and is not a part of the current extension of that act.

REGIONAL AND AREA COOPERATION

"To the small librarian the word co-operation is probably synonymous with interlibrary

loans . . . but is this co-operation? . . . since co-operation implies more or less equal partnership." (Snyder, 1961)

REGIONAL SUPPORT

Medical library cooperation has come to be almost synonymous with the hierarchy of leadership and services provided by Regional Medical Libraries and Regional Medical Program library projects. Regional Medical Libraries (RML) have document delivery as a primary objective; that is, the delivery of documented information--books and journals--via interlibrary loans. The RML viewpoint starts at the bureaucratice top, with the document collections of the National Library of Medicine and other large resource libraries. The RML program is concerned with establishing patterns of distribution, so that those documents can be used by the widest possible clientele. To facilitate distribution, some of these RMLs also provide consulting and manpower training programs for hospital libraries.

The Regional Medical Programs (RMP) have a primary goal of improving the quality of health care delivery to the patient. Quality health care depends on knowledge. The library concern of RMP programs begins at the bottom of the information delivery chain, with the patient and his doctor and the other members of his health care team. These are the people who need health care information. RMP library prbjects are concerned with identifying the information needs of the local community, and assisting the improvement of the local information center and its contacts with regional information resources. To accomplish these goals, RMP library projects are also involved in hospital library consulting and manpower training. RMPs and RMLs always cooperate closely in their training and consulting programs, so that their activities do not duplicate each other.

This three-pronged effort--training, consulting, and document delivery--is intended to extend local access to knowledge. It is not intended to replace local resources and initiative. No centralized service can be truly strong without understanding and support from the local level. No centralized service can respond to local needs without an informed group of local professionals to identify and interpret those needs.

Cooperative library projects at the city or area level can play a vital role in producing a foundation of strength for the national information network. Examples of area cooperation antedate the national system of Regional Medical Libraries. Their experience is the prototype for the national system.

We will need both moral and political support from many strong local cooperative groups if the national information delivery system is to continue at its present high level of service.

AREA COOPERATION AND INITIATIVE

The expense of library materials and the scarcity of trained library personnel underscore the importance of cooperation at local levels of hospital service.

Cooperative library programs may be based on various sizes of geographical areas: city, county, multi-county, or state. They depend on agreements of varying formality: verbal agreements, written memoranda of understanding, legal contracts, or papers of incorporation. Size of area and degree of formality are determined by the needs of the area and the complexity of the problems to be solved.

Existing educational and health care organizations can be used to provide a structure for library cooperation. State Hospital Associations or Area Health Education Centers may establish library divisions to serve all of their institutional members; or they may sponsor cooperative projects involving only a part of their institutional membership.

While RMP and RML library programs can provide leadership and advice, the real success of an area cooperative group will depend on local initiative, and on intimate knowledge of local problems and resources.

The literature on hospital libraries gives us several examples of successful cooperative groups. One of these programs is especially interesting because of its implications for Area Health Education Centers, as recommended by the Carnegie Commission on Higher Education (1970).

The Jacksonville Hospitals Educational Program, Incorporated (JHEP) was organized in Jacksonville, Florida, in 1958. It antedates similar Federal programs by several years. Its original financing came from an annual assessment against each of the six cooperating hospitals, reinforced by local contributions and a grant from a philanthropic organization. The assessment was based on a flat rate per hospital, plus an additional amount based on the number of patients admitted. Library cooperation was one of the earliest programs of JHEP. Other programs included a cooperative animal laboratory, a research program, basic science seminars, and closed-circuit television. (Michael, 1960)

In the spring of 1961 a Librarian-Coordinator was hired by JHEP to work with all six hospital libraries. It is particularly interesting to see how the hospital libraries have maintained their autonomy under coordination.

The Librarian-Coordinator is a professionally-trained medical librarian, accountable to the JHEP Executive Director. She is advised by a JHEP library committee composed of the six chairmen of the six hospital library committees, one hospital Director of Medical Education, one representative from the County Medical Society, and the Executive Director of JHEP, ex officio.

The Librarian works with the library committees of the individual hospitals in an advisory capacity only. She attends all meetings of these six committees and advises on new book purchases as well as policies. One of her important contributions is her central record of books newly-ordered by other hospitals. Books considered for purchase are compared to other hospitals' recent orders so that unnecessary duplication can be avoided. However, a decision to duplicate is the hospital's own prerogative if its own library committee feels that the duplication is necessary.

Libraries in the six hospitals are operated by nonprofessional "library technicians" trained by the Librarian-Coordinator. Library technicians are accountable to their own administrators and library committees, not to JHEP or to the Librarian-Coordinator. The JHEP library service depends on voluntary cooperation.

Besides the central order file, the Librarian-Coordinator catalogs all books purchased by the hospitals. She sends a set of cards for each book to each hospital, so that each library has a union catalog of all books available in the other hospitals. Library technicians file the cards in their catalogs. They do their own lettering and pasting to prepare books for use. They also answer routine reference questions and make their own arrangements to borrow books from other libraries within the city of Jacksonville.

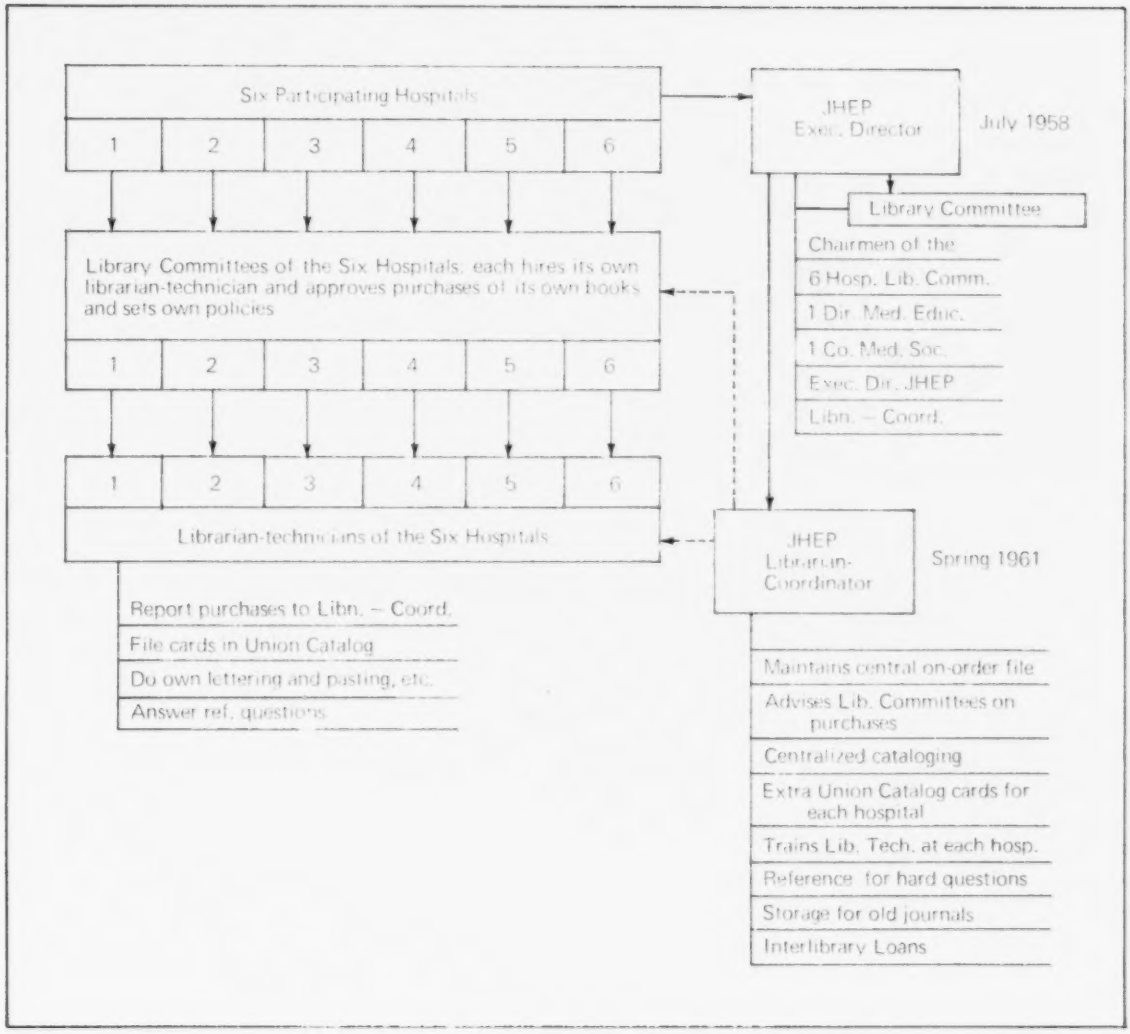
The Librarian-Coordinator answers difficult reference questions and arranges for interlibrary loans from sources outside Jacksonville. The JHEP office can provide central storage for old journals no longer heavily-used in the hospitals. (Feltovic, 1964)

This full description is not intended to endorse the JHEP operation as ideal, but only to stimulate thinking as to what might be possible. The Jacksonville experiment has a history of successful operation which is better than any amount of theorizing. It is a city-based program.

Sparsely-populated areas have their own problems to solve, and distance itself might indicate another base for organization. When hospitals are very widely-scattered, cooperation might

Figure 5

Jacksonville Hospitals Educational Program, Inc.



depend on sponsorship by a state-level organization such as a State Hospital Association or a university medical library. If state-level organizations provide the structure for area library services, then formal procedures must be established to insure continuing planning input from the hospitals which are to be served.

The JHEP example shows cooperation in continuing services. Such programs of continuing service require firm agreements and a defined level of financial support.

Less formal cooperative groups usually act together on single projects which can be completed in a short length of time. One example is the Detroit Medical Library Group, which met as a group as early as 1939. In 1946 the group published a union list of the journals owned by the

member institutions. The group has continued to issue publications and to sponsor research projects since that time.

Publications include a union catalog of new books received, cumulative yearly. Results of research projects are also published for distribution to members and to libraries outside the Detroit area. Cooperation has made it possible to do research studies of library operating costs, flow patterns of interlibrary loans, administrative patterns of member libraries, and the library needs of graduate medical education programs in the Detroit area.

More recently the loosly-organized Detroit Medical Library Group has sponsored a formal service agreement for a Central Medical Library Service which supplies coordination, shared collections, centralized purchasing of library materials, and other continuing services. (Cruzat, 1968)

Activities for area library cooperation can range all the way from a coordinated binding schedule (to insure that all copies of a given journal issue are not in the bindery at the same time) to highly centralized services (such as purchasing, cataloging, or audiovisual software pools and booking services.)

One key factor in the success of cooperative library projects is the understanding and agreement of the hospital administrators. Often it takes money to save money. To be effective, a cooperative library program requires the same study, planning, financing, controls, and accounting as a service within a single hospital. Without the guidance and approval of hospital administrators, library cooperation will be limited to what the librarians can do in their non-existent spare time.

GENERAL COMMENTS FOR ALL LIBRARIES

A CLOSE LOOK AT GIFTS

Many hospital libraries have been built on the basis of gifts. A knowledgeable donor can be the library's best friend, but more often potential donors need to be educated as to which gifts will really assist the work of the library. Cash gifts are always acceptable, of course. The hospital's usual public relations channels can be used to make known the specific titles and editions of texts which are needed, or titles and dates of needed journals. The doctors on your medical staff may donate these from their personal collections. Their patients might be encouraged to donate books when a piece of medical equipment would be too expensive for an individual gift.

However, all gifts must be carefully examined before they are accepted. Regardless of the proverb, the "gift horse" will cost something in upkeep. At the very least, you will have to provide shelf space for the books you accept.

Many complete and well-balanced libraries have been donated to hospitals by the widows of retired physicians. These were good libraries in their day, but often they do not contribute enough useful information to justify the time it would take to catalog them.

The hospital should have at least an inventory card for each book it owns, listing author, title, edition, publisher, and date. Collections of 60 to 100 titles need some kind of subject grouping to make it easier to find the books that the reader needs. This involves making title and subject cards and adding them to the basic inventory list. Collections of 300 titles or more require full classification according to one of the standard schemes of subject code-numbers, to help readers find the exact books which they are looking for. All of this record-keeping is what we mean by "cataloging."

If large numbers of old gift books are accepted by a small library, the collection may be forced to a sophisticated level of cataloging which would be unnecessary for the small number of current books which are really useful. If the library already has large numbers of current books, properly cataloged, then it is still wiser to spend the available time giving good service than to spend that same time cataloging old gift books of questionable value.

Sometimes a collection of old books is nice to have. If the hospital already has empty shelves which it plans to grow into, and does not want the bleak appearance of empty shelves (and if the donor of the gift books clearly understands what will happen) then accept the gift of old books. Separate the outdated books from the useful ones. Shelve the outdated books alphabetically by author without cataloging any of them. Mark them clearly as an older collection of possible historic interest. Then discard them gradually as shelf space is needed for new acquisitions. Above all, do not require the librarian to catalog an old gift collection. Do not force library users to search through outdated material to find useful, current references.

Accept no gifts without the donor's understanding that they will be added to the collection only if they are needed, and that they may be discarded or traded or sold as soon as they no longer serve the needs of the library's users. Always remember that the library is one of the hospital's clinical services. It does not have the primary function of a museum. The librarian's working tools must be as modern as those in the laboratory or the X-ray room. Be sure that the library's public relations emphasize the currency and usefulness of gifts which are accepted, so that potential donors will be educated in the library's real purpose in the hospital.

All of these comments apply equally to books which are transferred to the library from offices and laboratories. Be sure that the library does not become a graveyard for outdated editions while the current ones are inaccessible in private offices.

TWENTY-FOUR-HOUR ACCESS TO THE LIBRARY

The concept of full library service 24 hours a day is an ideal which only the largest institutions can achieve. Still, the ideal is worth working toward. Those who are responsible for library services should never forget that the night shift people have the same problems as the day people. In fact, the night shift may have more opportunity for study during the slow hours.

The problem is that without supervision the books disappear and soon there is no library. A library that is completely accessible 24 hours a day must be supervised 24 hours a day. Only the largest institutional budget can allow for round-the-clock library staffing. A library that is completely inaccessible when unstaffed fails to utilize its resources during two-thirds of the hospital's working day.

What compromises can be made between accessibility and security?

Monasteries used to put chains on the books. It works. We know of one hospital pharmacy which has done exactly that, drilling a hole through the upper left corner of each reference book. A loop of wire attaches the book to the chain. But accessibility is reduced. The reader cannot take the book to a comfortable chair to study. This solution is good only for the kind of book described: a reference tool in constant use by many people, providing short, factual answers and little discussion of principles.

Members of the medical staff usually have unrestricted access to the key to the library door. This is good for the medical staff. It doesn't help the nurses. The medical staff key has been held over from the days when the library was the doctor's library and the nurses had only what books happened to be on the ward -- usually the personal property of their supervisors. Some doctors will even take books home and fail to account for them. Some doctors have also forgotten to close and lock the door upon leaving.

Supervised night access to the library should be the privilege of every hospital employee. The policy can work if a single responsible person on the night shift is designated as "night librarian:" not necessarily sitting in the library all night, but carrying the key, opening the library when it is needed, helping the user find what he needs, checking books out for his home or office use, and locking the door again when the transaction is over. A night return slot in the library door could facilitate returning the books.

This system for night access could lead to positive benefits in service if the person responsible for the key (and, hence, the library) also knows how to use basic reference tools and how to relay special requests to the regular librarian. In effect, the "night librarian" would be giving Level I service.

In some hospitals such tight security may not be necessary. People who work together in small, isolated groups are more intimately acquainted, more dependent on each other, and seem to have a greater sense of responsibility to each other. Policies on access to the library will be governed by the same considerations as access to scientific instruments or to the refrigerator in the kitchen. The administrator must know his staff and must set policies accordingly.

CENTRALIZED LIBRARIES AND/OR STATION COLLECTIONS

The station collection is a small group of books specially selected for the needs of a particular ward in the hospital, and kept at the nursing station for easy access.

The greatest advantage of the station collection is its accessibility. Its greatest weakness is its lack of services: alerting service, literature searches, reference service, and interlibrary loans. Also, the station collection cannot handle a collection of journals, and these are necessary for current information.

Sister Aquinata (1968) has suggested station collections as a possible alternative to the centralized library in the small hospital. She has presented the pros and the cons of the matter very well. She emphasizes that the key to maximum use of the station collection is the nurse supervisor who encourages use of the books and guards against their disappearance.

We have found the same thing to be true in the very large hospital-medical center complex (University of Utah) where experimental "ward libraries" of medical texts were provided for interns and residents. Ward libraries showed most use and least loss where the Chief Resident, also in charge of the books, was most enthusiastic in promoting their use.

Ward libraries were used most heavily by the medical students and interns, and by the nurses when the books were accessible to them. Students and interns used the books for study purposes as well as for reference. The residents made heavy use of the books for reference, but their reading for study began to shift away from the texts, toward journals and monographs. The faculty physicians made less use of the ward collections, and used them only for reference. For their own needs the faculty depended on the more specialized monographs and more recent journals from the centralized library.

The effectiveness of the centralized library depends on service. Where the hospital librarian is a custodian, not giving service, there are always underground station collections tucked into odd corners of the wards, usually provided by the more concerned ward supervisors.

A centralized library must not decrease accessibility to books. That advantage of the station collection must be maintained. If the only available space for a larger collection is hard for the staff to reach, the the service-minded librarian may need to buy duplicate copies of certain basic texts to be placed at the nursing stations. Centralized control of the station collections would insure good selection of the materials and prompt replacement as new editions are published. If the staff cannot find the library easily, special efforts must be made to deliver library service to them, through telephone reference service, delivery and pick-up services, book lists, and simple public relations.

In summary, good station collections can serve as a stop-gap in smaller hospitals until a librarian can be hired. They may be a useful supplement to a centralized collection. They cannot provide journals, reference services, literature searches, alerting services, or interlibrary loans.

If the hospital must depend on station collections only, without a centralized library, then a special effort should be made to get advice from a competent librarian concerning initial selection and updating of the collections.

MULTIPURPOSE LEARNING FACILITIES

Area Health Education Centers

The emerging hospital-based Area Health Education Centers (Carnegie, 1970) will need to develop advanced learning facilities in the hospital. Community hospitals in Great Britain are already publishing the results of their experience with such facilities. The hospital learning center would group together the offices of the Director of Education, the Librarian and other education personnel, the library itself (shelves, books and study stations including audio-visual carrels), AV storage for hardware and software, a multi-purpose lecture room with the necessary AV equipment, and a "comfortable seminar room with armchairs and an intimate atmosphere." (Leather, 1971, p. 269)

A Library in the Conference Room

In adapting the learning center idea for smaller hospitals, the administrator should not try to combine the functions of library space and group meeting space. There will always be people who want to study or who need access to a book for quick reference, who cannot do so because a

meeting is in progress. It may be useful to plan multipurpose space for informal group study when meetings are not in session. However, a core of carrels or study tables must be physically separated from the group meeting space, providing access to the books, quiet for study, and help from the librarian.

LIBRARY SERVICES TO PATIENTS

Reading is good "therapy." It helps to pass the tedious hours of convalescence. Often it can help the patient in his mental adjustment to a disability. Guided reading can be a useful part of psychotherapy. Reading most certainly has educational value when the hospital patient must continue a particular regimen at home.

The smaller community hospital usually does not provide recreational reading for its acute patients. The volunteers may collect book donations from the community and distribute them informally from a book cart. Family and friends are glad to bring in materials from the public library, and the public library has a wide variety of material to suit all tastes.

All hospitals do have special responsiblity in providing educational materials to those patients whose recovery depends on learning how to live with a chronic condition. Often the public library can supply these materials as well, since the patient must have access to them after his return home. But the hospital cannot take this for granted. The hospital librarian should study the materials which will be needed. With the help of the medical staff she will compile a basic list of materials which should be readily available in the community. The public library is usually willing to make special purchases whenever they are suggested. However, the hospital should be prepared to purchase any patient education materials which cannot be shared as a community resource. Larger hospitals will have constant need for these materials, and will need to duplicate many titles which are already owned in other community libraries.

Extended-care facilities must give more attention to patients' recreational reading needs. This is particularly true when patients have no relatives or close friends in the community. Often the hospital does not have funds for this service. Public libraries have the books; the problem is manpower (or womanpower). This is a splendid project for the hospital auxilliary and the volunteers. Volunteers can give valuable library service to chronic care patients in several ways: 1) bringing a new collection of books to the hospital every month, for daily circulation from book trucks through the wards; 2) taking special requests from patients and obtaining those books from the public library; 3) arranging a bi-weekly bookmobile stop at the hospital, and acting as couriers between the bookmobile and the wards. The public library can usually supply large print books and Talking Books for the Blind.

If there is no public library in the community, the volunteers and their friends may have to start one. For advice, ask your state library commission, or other state library development agency.

The Veterans Administration Hospitals place great emphasis on their patients' libraries. VA hospitals have large populations of their own, often far from home and family. Bibliotherapy has been an important part of the VA library program for 30 years. A professional librarian with special training in psychology, learning theory, and medical sciences is sometimes called a bibliotherapist. This is a splendid program, but beyond the resources of most community hospitals. If bibliotherapy is needed, the professional librarians from the public or state library are usually glad to work with the patient's physician in designing such a program.

OTHER VIEWPOINTS

ON THE FUNCTION OF A HOSPITAL LIBRARY (David A. Kronick et. al., 1971)

"Does a collection of books, no matter how large, constitute a library if no one is assigned to the responsibility of supervising it? The Case Western Reserve study defines the hospital library in terms of having individuals to use it as a base for providing service. In this sense a library can exist with a minimum of books and journals and still provide excellent library service, as a switching center or channel to much wider resources than it could ever command itself."

ON ADMINISTRATIVE POLICY DECISIONS (Ralph T. Esterquest, 1964)

"The librarian and the hospital administrators need to reach agreement on several points. First they must decide what nearby library is the logical one to serve as the reservoir library, supplementing the local collection. When careful thought has been given to the many aspects of a total program, but at an early stage, an initial, exploratory conference with that reservoir library is eminently desirable, in order that both parties understand the matter being considered.

"A second point for the hospital to determine is the proportion of user requests to be met from the local shelves. Influencing this decision will be the data which the librarian can assemble concerning the success with which the present collection meets identified needs, but other important factors include the probable success of hoped-for arrangements with the potential reservoir library, and the amount of money the hospital is prepared to put into its own book acquisitions program.

"A third policy decision involves a recognition that the hospital library will henceforth emphasize service rather than resource-building. This is a very important shift in emphasis. Its implications must be clearly appreciated by all. The library staff will, under the program, devote proportionally less time to acquiring and cataloging materials, to binding periodicals, to custodial and housekeeping tasks, and will concentrate, instead, on supplying requested items diligently, speedily, and efficiently from whatever source, internal or external. In many hospital libraries, this will not be an easy step to take. It will be a traumatic experience to have the telephone replace the card catalog as the librarian's most important tool.

"The budget implications of the proposed new program should be seriously examined. Up to now, it has been felt perhaps that dollars spent for books and journals are those most wisely spent--they are dollars invested in all-time resources. Under the new program, the library budget might be divided in an entirely new way: ten percent for books and journals and ninety percent for staff, messenger service, telephone calls, photocopying fees, telefacsimile facilities rental, etc. If the hospital is truly interested in adequate library service, these budgetary decisions should follow naturally."

ON TRAINING FOR HOSPITAL LIBRARIANSHIP (Vern M. Pings, 1967)

"1. The hospital health science librarian has to spend more time evaluating publications than does the acquisitions librarian in a resource library. The latter has the task of buying everything published which falls within the language and subject scope of the library's acquisition policies. The hospital health science librarian has but two choices available in selecting materials: learn enough about the content of the literature to make wise choices, or devise methods to allow the library's users to select materials.

"2. The hospital health science librarian has to develop the opposite skill of selection, that of selecting for discard . . .

"3. Because the hospital health science library will have collections which consist of the most important and most used titles published, there is no need to engage in any detailed or

elaborate cataloging and classification. Cataloging can be purchased from the services of our national libraries . . . Any hospital health science librarian who insists that a uniquely developed cataloging system be maintained has lost a sense of the importance of his function.

"4. Although sophisticated cataloging skills need not necessarily be one of the hospital health science librarian's qualifications, an appreciation and understanding of bibliographic techniques is vital. The library is to serve as an access point through which the entire scholarly record can be acquired for any qualified user. Knowledge of the organization of resource libraries and how one locates and identifies specific documents is one of the most important skills the hospital health science librarian must possess. The interlibrary loan transaction is merely the reordering of the intellectual and bibliographic work that would have to be done if the document retrieval were done entirely in the resource library."

ON BOOKS AS CLINICAL TOOLS: THE DOCTOR'S VIEWPOINT (Kelly M. West, 1966)

Too Much Knowledge to Use? (June, 1966)

"The future physician will be called upon to apply a volume of knowledge many times greater than that which he can store in his cerebral cortex. Therefore, his effectiveness will, to an ever increasing extent, depend on his capacity to retrieve information rapidly . . . Clinical information not immediately at hand has a very limited utility. This is the main limitation of our present libraries in serving clinical practice directly . . . I suspect that most of us are not investing our very limited time in the most productive manner. We read and forget when we should scan and store. We can use the awesome volume of medical knowledge more effectively if we concentrate a little less on trying to remember information and a lot more on remembering where to find it."

Using Literature Indexes in Clinical Practice (July, 1966)

"A book on the doctor's shelf confirms the possible relationship of phenacetin and renal disease but he needs to know whether recent investigations have established that renal failure can occur with the amounts consumed by this particular patient. Thus the doctor needs some sort of index to find promptly the evidence on which to make the appropriate diagnostic decision.

"Suppose the doctor listens to a presentation on pulmonary disease and finds that he does not understand it very well. He concludes that, in order to provide modern and first-rate care to his patients with certain kinds of respiratory disorders, he needs to study a general review of recent progress in this field. He may turn to an index in order to find the paper or papers which best satisfy this need. The physician will want to take advantage of research advances as soon as possible after they become clinically applicable. Since this new information may be published in any one of several hundred journals the practitioner must scan some sort of index to identify and select with maximum efficiency those reports of recent research which appear to have greatest relevance to his own practice. He can then obtain these articles and decide which ones should be scanned, which should be read, which should be stored for possible retrieval, and which should be ignored. "Storage" of information can be achieved by filing a copy, or by filing information on where the article may be found, or by simply making a mental note of the journal and approximate date of the publication."

Hospital Libraries: Why They Aren't Working (October, 1966)

"Maintaining truly effective library services in a hospital is a more complex matter than is generally realized and, unfortunately, such a program may be rendered impotent by any one of several lesions. Before discussing these pathologic processes, let us review the anatomy and physiology of the hospital library briefly. The effectiveness of a hospital library depends on: 1. The quantity and quality of space provided; 2. its location; 3. the quality, quantity and relevance of its resources (books, journals and other information); 4. its services, which in turn are related to: 5.

the quantity and quality of manpower available to design and perform the services; 6. the capacities of the hospital's physicians to use the library as an instrument of clinical practice and education.

"Perhaps the principal reason for the foundering of hospital libraries is that the failure of any one of these six functional requirements will seriously damage or ruin the whole system . . . A good hospital library is primarily a service which only incidentally requires a collection as one of its resources.

"One of the reasons that hospital libraries don't work well is that responsiblity for them is usually divided between the hospital administration and the physicians who constitute the staff. The goals of the doctors and the hospitals are the same, but the division of responsibility makes it more difficult to establish and maintain library services. Although most hosital and their professional staffs have the financial and technical resources to establish a useful library program and the desire to do so, this is seldom accomplished. The hospital library is everybody's third priority; the need for library services is not urgently felt by any single element of the administration or hospital staff. . . .

"Most hospitals overcome some of these problems, but only a few surmont all of these difficulties and establish a program that really raises the level of practice in the hospital. The service which is probably most crucial in this regard is providing promptly the kinds of information required in solving the specific problems of the patient at hand. Unfortunately, this is the service which is often the weakest in the library program."

Clinical Potentialities of the Hospital Library (December, 1966)

"Many physicians regard patient-centered scholarship as an impractical pursuit because they think it is too time-consuming and they are skeptical of the capacity of the library to deliver useful information with sufficient promptness to help them in making clinical decisions. . . .But of all the various kinds of library-related scholarship, the mechanism of learning which has the greatest potential for the physician is the patient-centered scholarship that is a part of day-to-day decision-making. The hospital should, therefore, become an integral element of clinical practice. In order to do this, its services must be improved and extended. . . .For example, the physician should be able to call from the patient's bedside and request information much as he now orders laboratory tests. The hospital library should have a nucleus of information immediately at hand and should establish a functioning liaison with larger libraries. . . .Ideally, these larger libraries such as the Oklahoma Health Science Library would have staff members or consultants with clinical acumen. The practicing physician would explain the nature of his need by telephone to the librarian who in some situations would seek advice from one of the library's clinical consultants. This "clinical literature consultant" would then advise the librarian on how to perform the search or help in selecting the information of greatest relevance to the practitioner's need. Such searches would often be assisted by computers which would perform certain of these retrieval functions. Thus, a major role of the hospital library will be to exploit the rapidly developing resources of our national information system, the nucleus of which is the National Library of Medicine supplemented by the libraries of the major academic centers."

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APPENDIX

ADDRESSES

REGIONAL MEDICAL LIBRARIES

Intermountain Regional Medical Program

RML Regional Offices	Cooperating Resource Libraries
Pacific Northwest Regional Health Sciences Library University of Washington Seattle, Washington 98105	Library, Idaho State University Pocatello, Idaho 83201 Library, Montana State University Bozeman, Montana 59715 Idaho State Library 325 West State Street Boise, Idaho 83702
Midcontinental Regional Medical Library University of Nebraska Medical Center 42nd and Dewey Avenue Omaha, Nebraska 68105	University of Colorado Medical Center Denison Memorial Library 4200 East Ninth Street Denver, Colorado 80220 Spencer S. Eccles Medical Sciences Library University of Utah Salt Lake City, Utah 84112
Pacific Southwest Regional Medical Library Service Biomedical Library Center for the Health Sciences University of California Los Angeles, California 90024	Max C. Fleischmann Life Science Library University of Nevada Reno, Nevada 89507

Other Regional Medical Libraries
(Write for addresses of resource libraries)

New England Regional Medical
Library
Francis A. Countway Library of
Medicine
10 Shattuck Street
Boston, Massachusetts 02115

New York Regional Medical Library
New York Academy of Medicine
2 East 103rd Street
New York, New York 10029

East Central Regional Medical Library
Wayne State University Medical Library
645 Mullett Street
Detroit, Michigan 48226

South Central Regional Medical Library
Southwestern Medical School at Dallas
5323 Harry Hines Boulevard
Dallas, Texas 75235

Mid-Eastern Regional Medical
Library
College of Physicians of Philadelphia
19 South 22nd Street
Philadelphia, Pennsylvania 19103

(Mid-Atlantic Region)
National Library of Medicine
8600 Rockville Pike
Bethesda, Maryland 20014

Southeastern Regional Medical
Library
Woodruff Research Building
Emory University
Atlanta, Georgia 30322

Midwest Regional Medical Library
John Crerar Library
35 West 33rd Street
Chicago, Illinois 60616

OTHER AGENCIES

Extramural Program National Library of Medicine Bethesda, Maryland 20014	Disburses federal grants for library development and training of library manpower.
Medical Library Association 919 North Michigan Avenue Chicago, Illinois 60611	Provides opportunities for exchange of ideas through meetings and publications; operates a duplicate exchange service for institutional members.
Association of Hospital and Institution Libraries American Library Association 50 East Huron Street Chicago, Illinois 60611	Has a special concern in library services to patients as well as to medical and hospital staff; promotes cooperation with other libraries in the community.
Division of Library Services American Hospital Association 840 North Lake Shore Drive Chicago, Illinois 60611	Promotes quality in hospital libraries as a necessary supportive service in patient care, through standards, accreditation, training institutes, publications, and advisory services.
Biological Sciences Division Special Libraries Association 235 Park Avenue South New York, New York 10003	Sponsors meetings and publications. Provides advice on library problems through its Consultation Service.

JOINT COMMISSION ON ACCREDITATION OF HOSPITALS

PROFESSIONAL LIBRARY SERVICES

PRINCIPLE

The hospital shall provide services appropriate to the professional and technical needs of the medical and hospital staffs.

I. NATURE AND SCOPE OF SERVICES

STANDARD

Library services shall be made available to the medical and hospital staffs. There shall be books, periodicals and other materials appropriate to meet their needs.

1. Does the hospital provide professional library services for the medical staff and hospital personnel? ..... 1. ☐ P.1.1

   1. Yes, library services are offered for the medical staff and for other hospital personnel.
   2. Library services are offered for the medical staff only.
   3. No.

IF YOUR RESPONSE TO QUESTION 1 WAS NO, DO NOT COMPLETE THE PROFESSIONAL LIBRARY SERVICES SECTION OF THE QUESTIONNAIRE.

2. Supervision of the library services is a responsibility of: ..... 2. ☐ P.1.2

   1. Administration.
   2. Medical staff.
   3. Both of the above.
   4. Other (specify)_____

3. Is there a library committee? ..... 3. ☐ P.1.3

   1. Yes.
   2. No.

IF YOUR RESPONSE TO QUESTION 3 WAS NO, PROCEED TO QUESTION 6.

4. The library committee includes representatives from:
   (Mark the box ☒ of each applicable term or statement.) P.1.4(5)

   a. The medical staff ..... a. ☐
   b. Administration ..... b. ☐
   c. The nursing service ..... c. ☐
   d. The library service ..... d. ☐
   e. Other (specify)_____ e. ☐

5. The responsibilities of the library committee include:
   (Mark the box ☒ of each applicable term or statement.) P.1.5(3)

   a. Determination of the nature and scope of library services to be provided, on the basis of assessment of long-term and short-term needs ..... a. ☐
   b. Approval of the addition and deletion of titles, journals and related materials b. ☐
   c. Establishment of policies and procedures ..... c. ☐

6. If there is no library committee, indicate who performs the functions listed in Question 5.

_____

7. Does the hospital have the services of at least one professional librarian? ..... 7. | | P.1.7

1. Yes, as a full-time staff member.
2. Yes, as a part-time staff member.
3. Yes, as a consultant who is available on call.
4. No.

8. Indicate the number of employees on the library staff, including supervisory personnel: P.1.8(2)

a. Full-time ..... a. | | |
b. Part-time ..... b. | | |

9. Are library services provided in a central location? ..... 9. | | P.1.9

1. Yes, all library services are provided in one centralized location.
2. Some services are centralized while other services are provided within departments.
3. Library services are provided only in each department.
4. Library services are not provided.

10. If there is a central location where library services are provided, indicate the number of hours per day the library is open.
(Use whole numbers only. NO DECIMALS.) P.1.10(4)

a. Weekdays ..... a. | | |
b. Saturdays ..... b. | | |
c. Sundays ..... c. | | |
d. Holidays ..... d. | | |

11. The following library services are available:
(Mark the box ☒ of each applicable term or statement.) P.1.11(5)

a. Reference ..... a. ☐
b. Document delivery ..... b. ☐
c. Interlibrary loan ..... c. ☐
d. Audio-visual materials ..... d. ☐
e. Duplication ..... e. ☐

12. The following materials are available in the library:
(Mark the box ☒ of each applicable term or statement.) P.1.12(5)

a. Current editions of basic textbooks in fields related to services provided in the hospital ..... a. ☐
b. Current editions of basic sciences textbooks ..... b. ☐
c. Current and recent issues of relevant journals ..... c. ☐
d. **Index Medicus** and/or **Abridged Index Medicus** ..... d. ☐
e. **Hospital Literature Index** ..... e. ☐

13. The library collection includes:

a. Total number of titles, excluding journals ..... a. | | | | | P.1.13.1
b. Number of new titles added in last 12 months ..... b. | | | P.1.13.2
c. Number of current journal subscriptions ..... c. | | | P.1.13.3

14. Library materials are:
(Mark the box ☒ of each applicable term or statement.) P.1.14(3)

a. Catalogued ..... a. ☐
b. Identified as to ownership ..... b. ☐
c. Discarded when outdated ..... c. ☐

15. Are journals retained (in boxes, files, microfilms or bound volumes) according to the library's journal retention schedule? ..... 15. ⌊__⌋ P.1.15

1. Yes.
2. No.

16. There are established procedures covering:
(Mark the box ☒ of each applicable term or statement.) P.1.16(2)

a. Borrowing of library materials ..... a. ☐
b. Purchasing of new materials ..... b. ☐

17. Is there a regular budget item for the library? ..... 17. ⌊__⌋ P.1.17

1. Yes, it is included in the hospital budget.
2. Yes, it is included in the medical staff budget.
3. Other (specify)_____
4. No.

18. Comments by Respondent.

Use this space to clarify any of the questions in this portion of the questionnaire. When doing so, refer to the question by number.

_____

_____

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